EXHIBIT A-25

nonviolent crisis intervention
a CPI specialized offering

Understanding the Risks of Restraints

cpi

HCDE 02641

Understanding the Risks of Restraints

The *Nonviolent Crisis Intervention*® training program focuses on crisis prevention and the creation of restraint-free environments through a commitment to *Care, Welfare, Safety, and Security*℠. While considered a last resort, physical intervention procedures are taught as part of the program to provide staff with skills and confidence to safely manage emergency situations.

Any physical intervention should be used only when all other options have been exhausted and when an individual is a danger to self or others. Even in those moments, an assessment is still necessary to determine the best course of action to maintain the *Care, Welfare, Safety, and Security*℠ of all.

There may be times when other strategies, such as continuing verbal intervention, removing dangerous objects, using *Personal Safety Techniques*℠, and calling for further assistance would precede and possibly prevent any physical intervention.

Remember that there are risks involved in any physical intervention. Therefore, physical interventions should be considered only when the danger presented by the acting-out individual outweighs the risks of physical intervention. Specific laws or regulations may govern use of restraints. Be sure to check your facility's policies and procedures for applicable rules.

Dangers of Restraints

The events leading up to a crisis situation and the struggling that occurs during a restraint can result in a lot of stress for the individual being restrained. This negative stress is sometimes called distress. Consequently, it is not unusual for a restrained individual to show signs of distress, both physically and emotionally.

Always keep in mind that the acting-out person might have health problems. Therefore, everyone being restrained should be considered at risk. It is also important to understand that in some cases, restrained individuals have gone from a state of no distress to death in a matter of moments. Policies and procedures should reflect how staff can monitor these signs of distress and identify what protocol should be followed.

There is also a psychological danger in using restraints. Being restrained can be a frightening—even traumatic—experience. Restraints can interfere with the relationship between caregivers and the person being restrained. In fact, if people are restrained too often, they may begin to feel that they have no control over their lives.

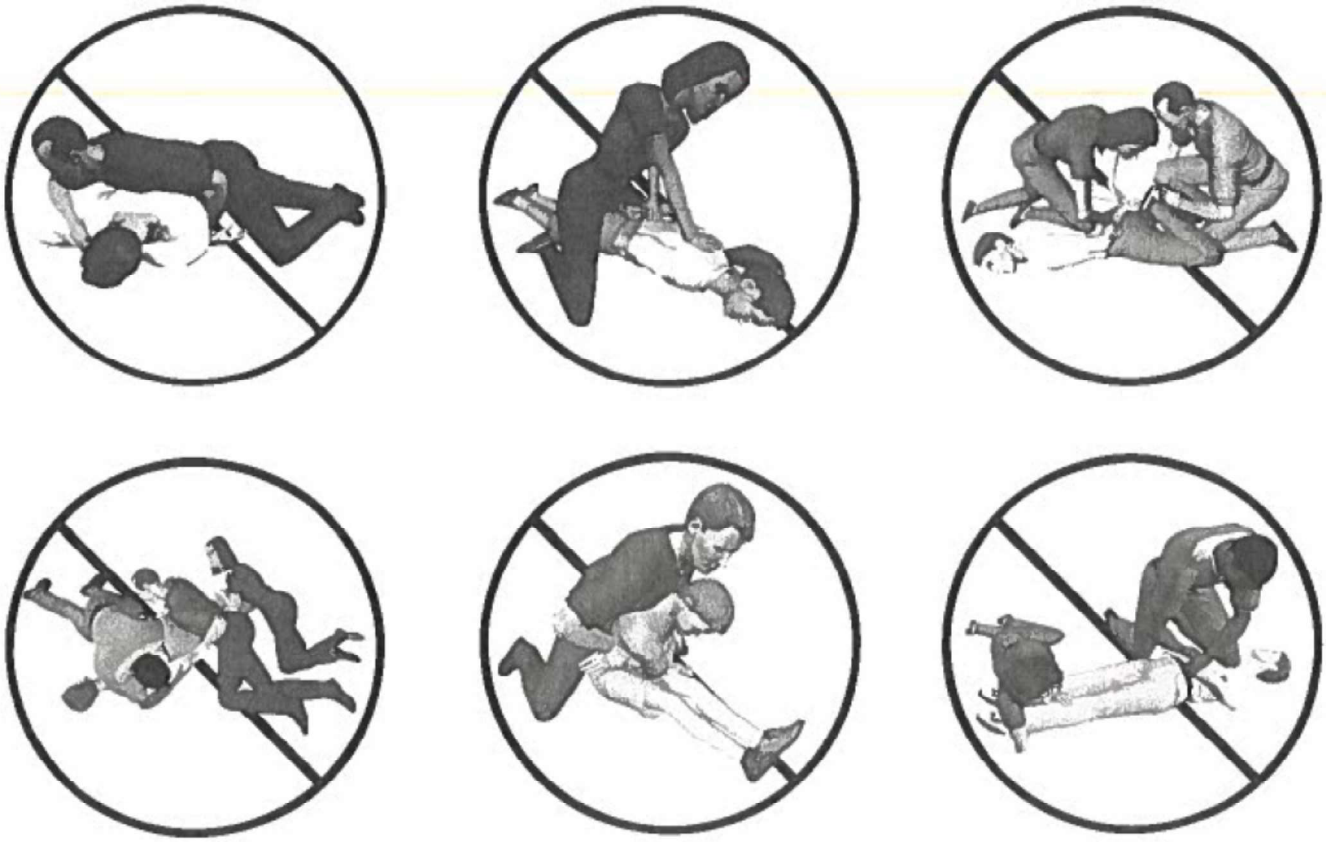
For these reasons and others, restraints should be used only when a person's behavior is MORE dangerous than the danger of using restraints.

Some restraints are more dangerous than others. For example, facedown (prone) floor restraints and positions in which a person is bent over in such a way that it is difficult to breathe are extremely dangerous. This includes a seated or kneeling position in which the person being restrained is bent over at the waist and any facedown position on a bed or mat.

Restraint-related positional asphyxia occurs when the person being restrained is placed in a position in which he cannot breathe properly and is not able to take in enough oxygen. Death can result from this lack of oxygen and consequent disturbance in the rhythm of the heart.

Staff members must be especially careful not to use their own bodies in ways that restrict the restrained person's ability to breathe. This includes sitting or lying across a person's back or stomach. When someone is lying facedown, even pressure to the arms and legs can impact that person's ability to breathe effectively.

Examples of High-Risk Positions for *Restraint-Related Positional Asphyxia*



Illustrations based on information from various individuals and resources. See Resources and References on page 32.

All of these positions may interfere with a person's ability to breathe. While they are different, these positions share a common factor: When forcefully maintained, each of them could prevent the diaphragm (the largest muscle of respiration) from working. If the diaphragm is not allowed to move down into the abdomen, breathing is seriously restricted. In fact, when a forcefully maintained position hinders both chest and abdomen movement—the result can be fatal.

When confronted with an emergency situation, always consider the option of disengaging. If the person is not a danger to self or others while on the floor, staff may make the decision to move away and give a clear directive.

Reducing the Risks of Restraints

There are ways to minimize risks involved in any physical intervention. The very best way to avoid injury is to avoid the need to restrain in the first place. Get to know the people in your care. Be aware of changes in their behavior that can be warning signs of anxiety. Intervene early. Learn to set limits effectively. Avoid being drawn into power struggles. Work as hard at learning verbal intervention skills as you do at learning physical intervention skills. Treat everyone with dignity and respect.

Staff members should be trained in and regularly practice safer ways of restraining. The physical intervention procedures taught in the *Nonviolent Crisis Intervention*® training program are designed to maximize safety and offer a safer alternative to techniques that involve the floor to restrain an individual. A physical restraint is an emergency procedure comparable to CPR or first aid. As with any emergency response procedure, staff members need to practice these skills on a regular basis.

Educate yourself and others on the risks and dangers of using restraints. Some restraints are more dangerous than others. By choosing safer restraint techniques, you and your facility can reduce the possibility of serious injury and even death. In particular, you should avoid positions that can lead to *restraint-related positional asphyxia*.

CPI's *Nonviolent Physical Crisis Intervention*℠ techniques are designed for safety and allow for a Therapeutic Rapport to be re-established with the individual who has lost control. Key elements of *Nonviolent Physical Crisis Intervention*℠ responses include:

- No element of pain is involved.
- The intent is to calm the individual.
- The individual is not restrained on the floor, thus reducing risks of *restraint-related positional asphyxia* and other injuries.
- Team interventions are used when necessary.
- *Nonviolent Physical Crisis Intervention*℠ is used only as a last resort when someone presents a danger.
- *Nonviolent Physical Crisis Intervention*℠ is used to protect—not to punish.

The goal is for staff to continually assess for signs of Tension Reduction and identify opportunities to re-establish a Therapeutic Rapport with the individual.

Remember, the best way to eliminate the dangers of restraints—to you and to those in your care—is to eliminate the need for restraints at all.

Glossary of CPI Terms

Acting-Out Person–the total loss of control, which results in a physical acting-out episode. It is the third level in the CPI *Crisis Development Model*℠. Individuals in this level are presenting a danger to themselves or others.

Anxiety–a noticeable increase or change in behavior. A nondirected expenditure of energy; e.g., pacing, finger drumming, wringing of the hands, or staring. It is the first level in the CPI *Crisis Development Model*℠.

Challenge Position–a body position in which one individual is face-to-face, toe-to-toe, and eye-to-eye in relation to another individual. This position is often perceived as a challenge and tends to escalate a crisis situation.

CPI Classroom Model–a standardized way of demonstrating personal safety and *Nonviolent Physical Crisis Intervention*℠ methods in order to show the application of basic principles.

CPI *COPING Model*℠–a model that staff members can use to guide them through the process of establishing Therapeutic Rapport with an individual after a crisis incident. The CPI *COPING Model*℠ can also be used as a way to structure a staff debriefing.

CPI *Crisis Development Model*℠–a series of recognizable behavior levels an individual may go through in a crisis, and corresponding Staff Attitudes/Approaches used for crisis intervention.

Defensive Level–the beginning stage of loss of rationality. At this stage, an individual often becomes belligerent and challenges authority. It is the second level in the CPI *Crisis Development Model*℠.

Directive Staff Attitude/Approach–an approach in which a staff member takes control of a potentially escalating situation by setting limits. It is the recommended Staff Attitude/Approach to an individual at the Defensive level.

Empathic Listening–an active process to discern what a person is saying.

Integrated Experience–the concept that behaviors and attitudes of staff impact behaviors and attitudes of individuals, and vice versa.

Kinesics–the nonverbal message transmitted by the motion and posture of the body.

Limit Setting–a verbal intervention technique in which a person is offered choices and consequences. Limits should be clear, simple, reasonable, and enforceable.

***Nonviolent Crisis Intervention*® Program**–a safe, nonharmful behavior management system designed to aid staff members in maintaining the best possible *Care, Welfare, Safety, and Security*℠ for agitated or out-of-control individuals even during their most violent moments.

***Nonviolent Physical Crisis Intervention*℠**–used only as a last resort when a person is a danger to self or others. This involves the use of safe, nonharmful control and restraint positions to safely control an individual until he can regain control of his behavior.

Paraverbal Communication–the vocal part of speech, excluding the actual words one uses. Three key components are tone, volume, and cadence of speech.

Precipitating Factors–the internal or external causes of an acting-out behavior over which a staff member has little or no control.

Proxemics–personal space. An area surrounding the body, approximately 1.5 to three feet in length, which is considered an extension of self.

Rational Detachment–the ability to stay in control of one's own behavior and not take acting-out behavior personally.

Supportive Staff Attitude/Approach–an empathic, nonjudgmental approach attempting to alleviate anxiety. It is the recommended Staff Attitude/Approach to an individual at the Anxiety level.

CPI *Supportive Stance*℠–the suggested body position for a staff member to maintain when intervening with a potentially out-of-control or acting-out individual. The CPI *Supportive Stance*℠ is maintained by keeping a distance of one leg-length from the person and by remaining at an angle.

Tension Reduction–a decrease in physical and emotional energy that occurs after a person has acted out, characterized by the regaining of rationality. It is the fourth level in the CPI *Crisis Development Model*℠.

Therapeutic Rapport–an approach used to re-establish communication with an individual who is experiencing Tension Reduction.

Training Process–a format for identifying ongoing learning opportunities to ensure training concepts expand upon course content through practical application. In addition to initial training, components include Formal Refreshers, Reviews, Policy Discussions, Practice, Situational Applications, and Rehearsals/Drills.

CPI *Verbal Escalation Continuum*℠–a model demonstrating a variety of defensive behaviors that are often seen when individuals are in the Defensive level of the CPI *Crisis Development Model*℠. This model includes suggested staff interventions for each behavior.

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Resources and References

CPI. (2006). *Instructor manual for the* Nonviolent Crisis Intervention® *training program.* Milwaukee, WI: Author.

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Miller, C. D. (2002). *Silent killer: Death by restraint.* Milwaukee, WI: CPI.

O'Halloran, R. L., & Frank, J. G. (2000). Asphyxial death during prone restraint. *American Journal of Forensic Medicine and Pathology, 21*(1), 39–52.

Patterson, B., Leadbetter, D., & McComish, A. (1998). Restraint and sudden death from asphyxia. *Nursing Times, 94*(44).

Pollanen, M., Chiasson, D., Cairns, J., & Young, J. (1998). Unexpected death related to restraint for excited delirium: A retrospective study of deaths in police custody and in the community. *Canadian Medical Association Journal, 158*(12).

Reak, K. (1996, June). Cocaine, restraints and sudden death. *The Police Chief.*

Reay, D. (1996, May). Suspect restraint and sudden death. *FBI Law Enforcement Bulletin.*

Weiss, E. M. (1998, October 11–15). Deadly restraint: A nationwide pattern of death. *Hartford Courant.*

Wright, S. (1999). Physical restraint in the management of violence and aggression in in-patient settings: A review of issues. *Journal of Mental Health, 8*(5).

Applied Physical Training℠ Refresher

Post-Test

Name_____ Date_____

Title_____

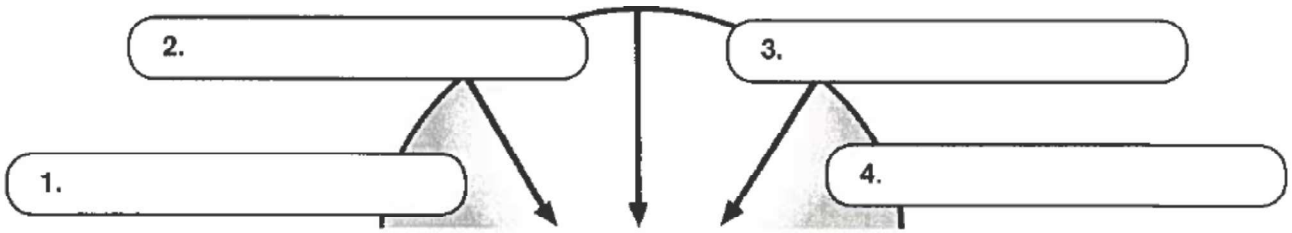
Facility_____ Phone_____

Facility Address_____

City_____ State/Province_____ Zip/Postal Code_____

Country _____ Email_____

1. What are the four phases of the CPI *Nonviolent Physical Crisis Intervention*℠ Continuum?



2. Identify one purpose for using the CPI *Nonviolent Crisis Intervention*® Classroom Models.

3. When should *Nonviolent Physical Crisis Intervention*℠ be used?

4. Name three ways to minimize the risks involved with physical interventions.
   -
   -
   -

5. How is the CPI *COPING Model*℠ used as a framework to minimize risks of future physical interventions?

6. What is the purpose of this course?

Applied Physical Training℠

Participant Evaluation

Instructor's initials _____
Did you pay for this program? __Yes __No
If yes, what fee did you pay?_____

Please indicate your response to each of the following items by circling the number that most appropriately expresses your opinion, using a scale of 5 (strongly agree) through 1 (strongly disagree). 5 = strongly agree; 4 = agree; 3 = neither agree nor disagree; 2 = disagree; 1 = strongly disagree.

Program Objectives:
As a result of completing this program, I believe that I have learned to:

Avoid high-risk control positions.
5 4 3 2 1

Apply principles of *Nonviolent Physical Crisis Intervention*℠ to adaptations and emergency situations.
5 4 3 2 1

Make use of CPI's Principles of Personal Safety to avoid injury to all involved in a crisis situation.
5 4 3 2 1

Use safe physical intervention procedures as a last resort when a person is a danger to self or others.
5 4 3 2 1

Problem solve when applying the principles and dynamics of *Nonviolent Physical Crisis Intervention*℠.
5 4 3 2 1

Instructor:
During the program, the Instructor:

Applied the course content to a variety of examples.
5 4 3 2 1

Stimulated interest in the subject matter.
5 4 3 2 1

Created an enjoyable learning atmosphere.
5 4 3 2 1

Emphasized the philosophy of *Care, Welfare, Safety, and Security*℠.
5 4 3 2 1

Content: (5 = highest; 1 = lowest)

The program content was relevant to my needs.
5 4 3 2 1

How would you rate the program overall?
5 4 3 2 1

As a result of this program, I _____

_____

_____

_____

Additional comments on the program, teaching methods, course materials, and/or the Instructor:

_____

_____

_____

_____

From time to time, we use comments from program participants in our promotional materials. If you'd agree to allow us to share your comments, please give us permission by signing here: _____

Thank you for your input. It is both valuable and necessary in maintaining the quality of the program.

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Notes:

Notes:

The staff of CPI thank you for your participation in our program. If we can be of any other assistance to you, your facility, or your colleagues, please do not hesitate to contact our office.

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